

PLEASE
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IN THIS
AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ **MEDICAID** ☐ **CHAMPUS** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN (SSN or ID)** ☐ **FECA BLK LUNG (SSN)** ☐ **OTHER (ID)** ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
JIMMY NULL

3. PATIENT'S BIRTH DATE ☐ **SEX** ☒ M ☐ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
NULL, JIMMY

5. PATIENT'S ADDRESS (No., Street)
CITY **STATE**

6. PATIENT RELATIONSHIP TO INSURED
Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
SAME

8. PATIENT STATUS
Single ☐ Married ☒ Other ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH ☐ **SEX** ☐ M ☐ F
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO
b. AUTO ACCIDENT? ☐ YES ☒ NO **PLACE (State)**
c. OTHER ACCIDENT? ☐ YES ☒ NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH ☐ **SEX** ☒ M ☐ F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
☐ YES ☒ NO *If yes, return to and complete item 9 a-d.*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ON FILE

14. DATE OF CURRENT: **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**
MM DD YY **03 07 97**

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
DR. H.M. DEBARTOLO JR.

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. **2. 3. 4.**

22. MEDICAL RESUBMISSION ☐ YES ☒ NO **ORIGINAL REF. NO.**

23. PRIOR AUTHORIZATION NUMBER

DATE(S) OF SERVICE		B	C	D	E	F	G	H	I	J	K
From	To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
03 07 97	03 07 97	0			1-3	95.00	1				
		0			1-3	265.00	1				
		0			1-3	68.00	1				
		0			1-3	30.00	1				
		0			1-3	100.00	1				
		0			2	85.00	1				
		0			1	995.00	1				

24. FEDERAL TAX I.D. NUMBER **SSN EIN** ☐ ☒

25. PATIENT'S ACCOUNT NO. **27. ACCEPT ASSIGNMENT? (For govt. claims, see back)** ☒ YES ☐ NO

28. TOTAL CHARGE **29. AMOUNT PAID** **30. BALANCE DUE**
\$1,648.00 \$ \$1648.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER **32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)**
3-12-97 **MAR 28 1997**

33. PHYSICIAN'S, SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE #
Dr. Hansel M. DeBartolo Jr
11 DeBartolo Drive Sugar Grove, Illinois 60554

EXHIBIT A

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

W. A. Haynes & Company

PLEASE
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AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ **MEDICAID** ☐ **CHAMPUS** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN (SSN or ID)** ☐ **FECA BLK LUNG (SSN)** ☐ **OTHER** ☐ **PICA** ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
JIMMY NULL

3. PATIENT'S BIRTH DATE ☐ **SEX** ☒ M ☐ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
NULL, JIMMY

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
SAME

8. PATIENT STATUS
Single ☐ Married ☒ Other ☐
Employed ☒ Full-Time Student ☐ Part-Time Student ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO
b. AUTO ACCIDENT? ☐ YES ☒ NO
c. OTHER ACCIDENT? ☐ YES ☒ NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ON FILE **DATE**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ON FILE

14. DATE OF CURRENT: **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**
MM DD YY **03 10 97**

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
DR. H.M. DEBARTOLO JR.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 21 BY LINE)
1. L
2. L
3. L
4. L

22. MEDICAID RESUBMISSION CODE **ORIGINAL REF. NO.**

23. PRIOR AUTHORIZATION NUMBER

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
03	10	97	03	10	97	0			1-3	95.00	1										
						0			1-3	265.00	1										
						0			1-3	68.00	1										
						0			1-3	30.00	1										
						0			1-3	100.00	1										

24. FEDERAL TAX I.D. NUMBER **SSN EIN** ☐ ☒

25. PATIENT'S ACCOUNT NO. **27. ACCEPT ASSIGNMENT? (For govt. claims, see back)** ☒ YES ☐ NO

26. TOTAL CHARGE \$ **558.00** **29. AMOUNT PAID** \$ **558.00** **30. BALANCE DUE** \$ **558.00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER **EXHIBIT B**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
3-12-97

33. PHYSICIAN'S, SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE #
Dr. Hansel M. DeBartolo Jr
1 DeBartolo Drive Sugar Grove, Illinois 60054

HEALTHSTAR HOSPITAL ONLY CLIENT

ELIGIBLE

APR 01 1997

MAR 28 1997

tabbles

SIGNED

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90). FORM RRB-1500

HEALTH INSURANCE CLAIM FORM

PICA ☐ ☐ ☐

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

DATE _____

SIGNED ON FILE

REFERRING PHYSICIAN

HEALTHSTAR

HOSPITAL ONLY

CLIENT

DATE BY LINE

22. MED
COD

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
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23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)

<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
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28. TOTAL CHARGE	AMOUNT PAID
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30. BALANCE DUE	
\$6000.00	

1. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

EXHIBIT

SIGNED

DATE -

PIN#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/68)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500
APPROVED OMB-1215-0055 FORM OWCP-1500

EXHIBIT

Q

MAR 31 1997

HEALTHSTAR

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM										PICA			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JIMMY NULL										3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) SAME	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/> Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>		13. EMPLOYER'S NAME OR SCHOOL NAME VALLEY LINEN	
14. OTHER INSURED'S POLICY OR GROUP NUMBER										15. INSURED'S POLICY OR GROUP NUMBER		16. INSURANCE PLAN NAME OR PROGRAM NAME PCN PREFERRED CARE NETWORK	
17. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										18. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.		19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
20. EMPLOYER'S NAME OR SCHOOL NAME HEALTHSTAR HOSPITAL ONLY										21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										24. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		25. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
26. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 03 21 97										27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 03 10 97		28. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
29. NAME OF Referring PHYSICIAN OR OTHER SOURCE DR. H.M. DEBARTOLO JR.										30. LD. NUMBER OF REFERRING PHYSICIAN		31. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
32. RESERVED FOR LOCAL USE										33. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		34. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
35. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										36. PRIOR AUTHORIZATION NUMBER		37. PHYSICIAN'S, SUPPLIER'S, OR OTHER NAME, ADDRESS, ZIP CODE & PHONE #	
38. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 21 97 03 21 97										39. PLACE OF SERVICE B C 0		40. TYPE OF SERVICE D 0	
41. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 1-3										42. DIAGNOSIS CODE 1-3		43. \$ CHARGES 95.00	
44. DAYS OR UNITS 1										45. EPSDT Family Plan 1		46. EMG 1	
47. COB 1										48. RESERVED FOR LOCAL USE		49. APR 08 1997	
50. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										51. PATIENT'S ACCOUNT NO.		52. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
53. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 03-24-97										54. TOTAL CHARGE \$ 558.00		55. AMOUNT PAID \$ 558.00	
56. SIGNATURE INCLUDING (I certify that apply to this claim) EXHIBIT D										57. PHYSICIAN'S, SUPPLIER'S, OR OTHER NAME, ADDRESS, ZIP CODE & PHONE # Dr. Hansel M. DeBartolo Jr 11 DeBartolo Drive Sugar Grove, IL 60054		58. BALANCE DUE \$ 558.00	

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTHSTAR HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JIMMY NULL		3. PATIENT'S BIRTH DATE MM DD YY 07 25 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY		5. PATIENT'S ADDRESS (No., Street) SAME	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) SAME	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/> Employed <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S DATE OF BIRTH MM DD YY 03 24 97 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 03 24 97		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 03 21 97	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		19. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
20. PRIOR AUTHORIZATION NUMBER		21. RESERVED FOR LOCAL USE	

HEALTHSTAR
CLIENT

22. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify apply to)		23. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		24. TOTAL CHARGE		25. AMOUNT PAID		26. BALANCE DUE	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		29. TOTAL CHARGE \$ 558.00		30. AMOUNT PAID \$		31. BALANCE DUE \$ 558.00	
32. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify apply to)		33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		34. PHYSICIAN'S, SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE #		35. PHYSICIAN'S, SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE #		36. PHYSICIAN'S, SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE #	

EXHIBIT

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03-24-97

ELIGIBLE

APR 15 1007

Dr. Hansel M. DeBartolo Jr

PIN 1 DeBartolo Drive Sugar Grove, Illinois 60554

Wj Haynes
Chgo Ill 60645

HEALTH INSURANCE CLAIM FORM									
MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
3. PATIENT'S BIRTH DATE MM DD YY 07 25 59					4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY				
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) SAME AS PATIENT				
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER VALLEY LINEN				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DR. H.M. DEBARTOLO, JR.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE NULL, JIMMY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 04 04 97					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DR. H.M. DEBARTOLO, JR.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
22. PRIOR AUTHORIZATION NUMBER					23. PRIOR AUTHORIZATION NUMBER				
24. DATE OF SERVICE FROM MM DD YY TO MM DD YY 04 04 97 04 04 97					25. DATE OF SERVICE FROM MM DD YY TO MM DD YY 04 04 97 04 04 97				
26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 558.00					29. AMOUNT PAID \$ 558.00				
30. BALANCE DUE \$ 558.00					31. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Dr. Hansel M. DeBartolo Jr 11 DeBartolo Drive Sugar Grove, Illinois 60554				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT

F

4-4-97

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90) FORM RRR-1500

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM														
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY					3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) SAME CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME Suburban Teamsters of No. 11 Valley Linen c. INSURANCE PLAN NAME OR PROGRAM NAME P.C.N. Preferred Plan Network				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED ON FILE DATE					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED ON FILE									
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 04 15 97					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DR. H.M. DEBARTOLO, JR					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.					23. PRIOR AUTHORIZATION NUMBER					24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE				
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse are true and correct.) EXHIBIT G DATE					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Delnor Community Hosp. 300 Randall Rd. Geneva, IL., 60134					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Dr. Hansel M. DeBartolo Jr Drive Sugar Grove, Illinois 60554 PIN# GRP#				

ELIGIBLE
MAY 21 1997

MAY 16 1997

W. J. Haynes, Jr 60645

HEALTH INSURANCE CLAIM FORM

MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) SAME AS PATIENT	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER 11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> 12. EMPLOYER'S NAME OR SCHOOL NAME VALLEY LINEN 13. INSURANCE PLAN NAME OR PROGRAM NAME P.C.N. PREFERRED PLAN NETWORK 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 558.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 558.00	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 4-21-97		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE \$ PHONE # Dr. Hansel M. DeBartolo Jr 11 DeBartolo Drive Sugar Grove, Illinois 60554	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT

H

tabbles

RECEIVED
MAY 06 1997

FOR: Jimmy Null

AMOUNT: \$1,310.40

CHECK NO: 1107863

DATE INCURRED: 03/07/1997

PT#: n

ISSUE DATE: 01107863
04/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO. - ELGIN, ILL.PAY THE SUM OF 1,310 DOLLARS 40 CENTS
TO THE ORDER OF

PAY DOLLARS: \$1,310.40

DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554**NOT NEGOTIABLE**

AUTHORIZED SIGNATURE

⑈1107863⑈ ⑈01100793⑈ ⑈960666⑈

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO.	CHECK AMOUNT
04/22/1997	01107863	\$1,310.40

DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

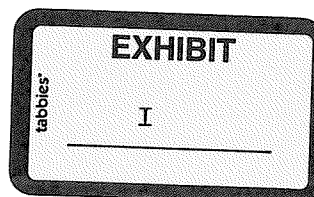
Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO					
MO.	DAY	MO.	DAY	WKS	DAYS		

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	



CLAIM FILE COPY



FOR: Jimmy Null

AMOUNT: \$446.40

CHECK NO: 1107864

DATE INCURRED: 03/10/1997

PT#:

ISSUE DATE: 04/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO. - ELGIN, ILL.

PAY THE SUM OF 446 DOLLARS 40 CENTS

PAY DOLLARS:

AMOUNT OF CHECK
\$446.40

DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

⑈1107864⑈ ⑆071900443⑆ ⑈950⑈666⑈

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO	CHECK AMOUNT
04/22/1997	01107864	\$446.40

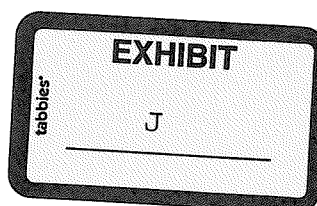
DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

LOSS OF TIME						AMOUNT	CODE
FROM		TO		WKS	DAYS		
MO.	DAY	MO.	DAY				

Jimmy Null

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	

CLAIM FILE COPY



FOR: Jimmy Null

AMOUNT: \$6,000.00

CHECK NO: 1107866

DATE INCURRED: 03/18/1997

PT#:

ISSUE DATE: 04/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO. - ELGIN, ILL.

PAY THE SUM OF 6,000 DOLLARS 00 CENTS

PAY DOLLARS: \$6,000.00

DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

⑈1107866⑈ ⑈071100993⑈ ⑈950⑈666⑈

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO	CHECK AMOUNT
04/22/1997	01107866	\$6,000.00

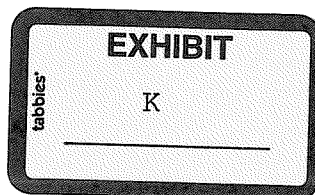
DAYS	HOSPITAL	SURGICAL	MEDICAL	XRAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO		WKS	DAYS		
MO.	DAY	MO.	DAY				

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	

CLAIM FILE COPY



FOR: Jimmy Null

AMOUNT: \$446.40

CHECK NO: 1107868

DATE INCURRED: 03/21/1997

PT#

ISSUE DATE: 04/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO. - ELGIN, ILL.

PAY TO THE ORDER OF 446 DOLLARS 40 CENTS

PAY DOLLARS: \$446.40

DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

#1107868# 0071900993# 0460666#

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO	CHECK AMOUNT
04/22/1997	01107868	\$446.40

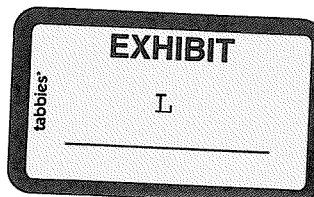
DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE		

Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO		WKS	DAYS		
MO.	DAY	MO.	DAY				

MEMBER NUMBER	LOCAL	EMPLOYER NO
	142	

CLAIM FILE COPY



FOR: Jimmy Null

AMOUNT: \$446.40

CHECK NO: 1107869

DATE INCURRED: 03/24/1997

PT#:

ISSUE DATE: 01/07/859
04/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO. - ELGIN, ILL.

PAY THE SUM OF 446 DOLLARS 40 CENTS
TO THE ORDER OF

PAY DOLLARS: \$446.40

DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

⑈1107869⑈ ⑈011900943⑈ ⑈960-222⑈

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	0

DATE	CHECK NO.	CHECK AMOUNT
04/22/1997	01107869	\$446.40

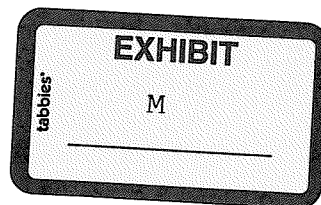
DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

LOSS OF TIME						AMOUNT	CODE
FROM		TO					
MO.	DAY	MO.	DAY	WKS	DAYS		

Jimmy Null

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	

CLAIM FILE COPY



FOR: Jimmy Null

AMOUNT: \$446.40

CHECK NO: 1111425

DATE INCURRED: 04/04/1997

PT#:

ISSUE DATE: 05/06/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
 & TRUST CO. - ELGIN, ILL

PAY THE SUM OF 446 DOLLARS 40 CENTS
 TO THE ORDER OF

PAY DOLLARS:

AMOUNT OF CHECK
\$446.40

DeSartolo MD, Dr H
 11 De Bartolo Drive
 Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

#1111425# 6071900993# 960-666#

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO.	CHECK AMOUNT
05/06/1997	01111425	\$446.40

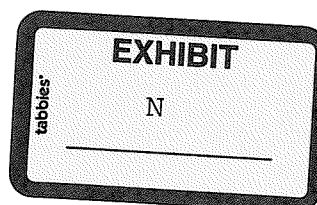
DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO		WKS	DAYS		
MO.	DAY	MO.	DAY				

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	

CLAIM FILE COPY



CLAIMS OFFICE

7045 N. WESTERN AVENUE
CHICAGO, IL 60645-3488
(312) 338-8500

CLAIM INFORMATION FORM Page 1
07/10/1997

Jimmy Null

ENROLLEE: Jimmy Null
PATIENT: Null, Jimmy
ACCOUNT: Suburban Teamsters Local 142
POLICY NO:
S.S. NO.:
CLM NO:
PROCESSOR: Lisa Biegacz

KEEP THIS STATEMENT FOR TAX PURPOSES
NO OTHER RECORD WILL BE PROVIDED

*IF CODE PRESENT SEE REMARKS BELOW

NATURE OF SERVICE/PROVIDER	DATE OF SERVICE:		TOTAL CHARGE	INELIGIBLE		AMOUNT @ %	AMOUNT @ %	AMOUNT @ %	AMOUNT @ 100%
	FROM	TO		AMOUNT	CODE				
DeBartolo MD, D	04/15/97	04/15/97	8752.23	7513.39	27				1238.84
DeBartolo MD, D	04/15/97	04/15/97	247.77						247.77
TOTALS			9000.00	7513.39					1436.61
				LESS DEDUCTIBLE					
				BALANCE					1436.61
				CO-PAYMENT %			%	%	100 %
				BENEFIT					1436.61
				TOTAL BENEFIT					1436.61
									1436.61

DESCRIPTION OF REMARKS/BENEFITS

27 Adjustment payment to Usual & Customary
Charges are over our usual and reasonable

PAYABLE TO	CHECKS ISSUED	AMOUNT	DATE
DeBartolo MD, Dr H 1 De Bartolo Drive Ugar Grove IL 60554	01125045	1436.61	07/10/97

EXHIBIT

O

tabbles

FOR: Jimmy Null AMOUNT: \$1,486.61 CHECK NO: 1125045
 DATE INCURRED: 04/15/1997 PT#: 01125045
 PAYEE TAX IDENTIFICATION NO: ISSUE DATE: 07/10/1997
 PAY THE SUM OF 1.486 DOLLARS 61 CENTS
 TO THE ORDER OF

UNION NATIONAL BANK
 & TRUST CO. - ELGIN, ILL.

AMOUNT OF CHECK
 \$1,486.61

PAY DOLLARS:

DeBartolo MD, Dr H
 11 De Bartolo Drive
 Sugar Grove IL 60554

NOT NEGOTIABLE
 AUTHORIZED SIGNATURE

⑈1125045⑈ ⑆07100493⑆ ⑆980⑈666⑈

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS	DATE	CHECK NO.	CHECK AMOUNT
Jimmy Null	Employee	37	D	07/10/1997	01125045	\$1,486.61

DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO		WKS	DAYS		
MO.	DAY	MO.	DAY				

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	



CLAIM FILE COPY

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

FOR: Jimmy Null

AMOUNT: \$446.40

CHECK NO: 1115689

DATE INCURRED: 04/21/1997

PT#:

0115689
ISSUE DATE: 05/22/1997

PAYEE TAX IDENTIFICATION NO:

UNION NATIONAL BANK
& TRUST CO, - ELGIN, ILL.PAY THE SUM OF
TO THE ORDER OF

446 DOLLARS 40 CENTS

PAY DOLLARS:

AMOUNT OF CHECK
\$446.40DeBartolo MD, Dr H
11 De Bartolo Drive
Sugar Grove IL 60554

NOT NEGOTIABLE

AUTHORIZED SIGNATURE

#1115689# 4071400993# #960#666#

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

DEPENDENT (IF APPLICABLE)	RELATIONSHIP	AGE	CLASS
Jimmy Null	Employee	37	D

DATE	CHECK NO.	CHECK AMOUNT
05/22/1997	01115689	\$446.40

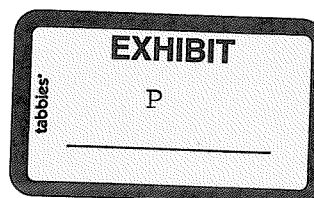
DAYS	HOSPITAL	SURGICAL	MEDICAL	X-RAY/LAB	MATERNITY	OTHER BENEFITS	CODE	OTHER BENEFITS	CODE

Jimmy Null

LOSS OF TIME						AMOUNT	CODE
FROM		TO					
MO.	DAY	MO.	DAY	WKS	DAYS		

MEMBER NUMBER	LOCAL	EMPLOYER NO.
	142	

CLAIM FILE COPY



CLAIMS OFFICE
7045 N. WESTERN AVENUE
CHICAGO, IL 60645-3488
(312) 338-8500 • FAX: (312) 338-8995

Page: 1

May 28, 1997

DeBartolo MD, Dr H
11 De Bartolo Drive

Sugar Grove IL 60554

Re: Claim No:
Claimant: Jimmy Null
Insured: Jimmy Null
Group No: 1

Dear DeBartolo MD, Dr H

This is to advise you that the Claim Department for Suburban Teamsters is in receipt of your recent claim. However, before processing your claim, it is necessary that we request that you furnish us with additional information.

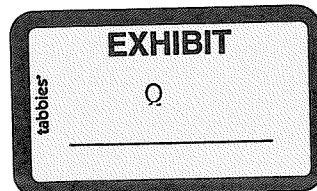
4/15/97 Dr H DeBartolo

Please justify your fee of \$9000.00 for the above dated (see attached). The charge is considerably over our usual and customary.

You may be assured that as soon as the above requested information is received, we will give your claim immediate attention. If you have any questions, please feel free to contact our office.

Sincerely,

Claims Department



DeBartolo Clinic

DeBartolo Clinic

11 DeBartolo Drive
Sugar Grove, Illinois 60554

Phone: 630-859-1818

Fax: 630-859-1830

E-mail: debartolo@americamail.com

Wednesday, March 25, 1998

PCN
7257 N. Lincoln Ave
Lincolnwood, IL 60646

Re: Jimmy Null

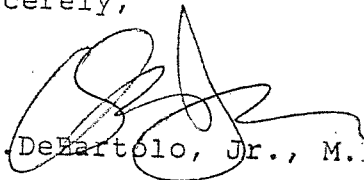
Dear Administrator:

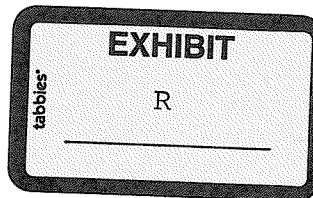
We wish to formally protest the amount allowed for this surgery. More should have been allowed.

Should you have any questions, please contact Dr. DeBartolo, Jr. at the above address.

Thank you.

Sincerely,


H.M. DeBartolo, Jr., M.D., J.D.



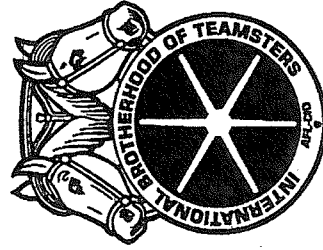
APR 22 1998

APR 17 1998

HEALTH & WELFARE PLAN OF BENEFITS

PROVIDED BY THE

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND



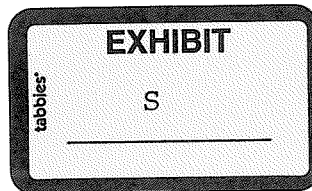
SUMMARY PLAN DESCRIPTION

BENEFITS IN EFFECT AS OF
JANUARY 1, 1996

EIN: 36-6158494



PN:501



DEFINITIONS

In this booklet, the use of a masculine personal pronoun (he, him, his) includes the feminine (she, her, hers) wherever it is required. Spouses are usually referred to in the feminine gender, but the masculine gender applies where applicable. Also, where the words "you" or "your" are used, it means an employee.

AMBULATORY SURGICAL CENTER—A health care facility in which surgery is performed on patients on an outpatient basis. In order to be an approved ambulatory surgical center for the purposes of this Plan, it must meet all of the following requirements: (1) It must be licensed and supervised by a full-time M.D. and keep medical records on all patients; (2) It must employ a licensed anesthesiologist and a registered nurse, and the doctor who performs the surgery must also be allowed operating privileges at a local hospital; and (3) It must have at least two operating rooms and a recovery room, be equipped to take care of emergencies and have an agreement with a local hospital to take patients who develop problems.

CALENDAR YEAR—The 12-month period starting on January 1 of any year and ending on December 31 of that year.

COLLECTIVE BARGAINING AGREEMENT—Any applicable negotiated labor agreement existing between an employer and a union which provides for contributions to the Fund as well as any extensions, amendments or renewals, or any such new labor agreement executed in the future.

CONTRIBUTIONS—Payments made by a contributing employer to the Fund on behalf of its employees.

COVERED; COVERED UNDER THE PLAN—A person is eligible to receive benefits under this Plan.

COVERED EMPLOYMENT—Work that you perform for a contributing employer for which the employer is required to make contributions to the Fund on your behalf.

COVERED EXPENSES; COVERED MEDICAL EXPENSES—The reasonable and customary charges necessarily incurred by a covered person for medical, vision, dental and orthodontic care and treatment which are eligible to be considered for payment under the Plan, subject to the provisions, limitations and exclusions of the Plan.

COVERED PERSON—An eligible employee and any person in his family or household who meets the definition of a dependent.

DEPENDENT

1. Your spouse, while not legally separated from you. If your spouse is a full-time active member of the military service or armed forces of any country or nation, she is not considered a dependent under this Plan. (See page 40 under COBRA Coverage for an exception to this rule.)

2. Your unmarried child (see "Definition of Child" below):

- Who is less than 19 years old; or
- Who is age 19 but less than age 24, provided he is a registered full-time student in an accredited secondary school, college, or university or in a vocational or technical trade school or institute and is dependent upon you for the major portion of his support and maintenance; *however, a child who is age 19 or older is not eligible for benefits for alcoholism, drug abuse, mental or nervous disorders, self-inflicted injury or orthodontic treatment; or*
- Who is age 19 or older and who is incapable of self-sustaining employment because he is disabled due to mental incapacity, mental retardation, or physical disability. The coverage of such a child will be continued for as long as you are eligible and all of the following requirements are met:

- The child must have become disabled before becoming age 19 and must remain disabled;
- The child must be dependent on you for the major portion of his support and maintenance (except to the extent that he is supported by another parent, is receiving governmental aid or assistance, or is the beneficiary of another trust);
- The child must meet the requirements of the definition of a child except for age; and
- At the time the first claim is filed on behalf of the child, you must furnish proof, at no expense to the Plan, that the child was so disabled before becoming age 19. However, if the required proof includes a physical examination of the child by a doctor, the Plan will pay for the exam. If you do not provide the proper proof, the child will not be covered beyond the date he becomes age 19. You must furnish proof of the child's continued disability from time to time thereafter if requested by the Trustees (but not more often than once in a 12-month period). If proof is requested but not received on or before the date set by the Trustees, the child's coverage will terminate on that date.

If a child works for a contributing employer and is eligible for benefits under this Plan as an employee, or if the child is a full-time active member of the military service of any country, the child is not considered a dependent under this Plan. (See page 40 under "COBRA Coverage" for an exception to this rule.)

L.P.N.—A Licensed Practical Nurse.

MEDICALLY NECESSARY—Only those services, treatments, or supplies provided by a hospital, a doctor, or other qualified provider of medical services and supplies, that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an injury or sickness. To be considered medically necessary, the service, treatment or supply must be consistent with the symptoms or diagnosis and treatment of the condition, disease, sickness or injury; must be appropriate according to standards of good medical practice and be the most appropriate service or supply which can safely be provided to the patient under the circumstances; must not be solely for the convenience of the patient, the doctor, or the hospital; could not be omitted without adversely affecting the patient's condition or the quality of medical care; and is not experimental or investigative.

MENTAL OR NERVOUS DISORDER—A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, including alcoholism, drug abuse and drug addiction, and regardless of any physiological or traumatic cause or origin of such condition.

PARTICIPATION AGREEMENT—A written agreement between the Board of Trustees and an employer who has a collective bargaining agreement with one of the participating Local Unions of this Plan whereby the employer agrees to make and the Trustees agree to accept contributions to the Fund on behalf of the employer's employees who are not members of the bargaining group.

PERMANENT AND TOTAL DISABILITY—A disability which you suffer as a result of a physical or mental condition which completely prevents you from engaging in any occupation for wage or profit; which has existed for at least 9 or more consecutive months; and which is presumably permanent. To be considered a permanent and total disability, the disability must be established to the satisfaction of the Trustees based upon competent medical evidence.

PLAN; BENEFIT PLAN—The Health and Welfare Plan of Benefits summarized in this booklet.

PRE-EXISTING CONDITION—A sickness, injury, disease, or other physical or mental condition of an employee or dependent:

1. That was diagnosed or treated by a doctor, or for which the employee or dependent received any medical care, services, or supplies (including the use of prescription drugs or medicines), during the six months immediately before the employee's or dependent's effective date of benefits; or
2. That produced symptoms during the six months immediately before the employee's or dependent's effective date of benefits and those symptoms would have caused an ordinarily prudent person to seek medical diagnosis or treatment.

Pregnancy and pregnancy-related conditions of female employees and spouses of male employees which exist on their effective date of benefits are not included as pre-existing conditions.

R.N.—A Registered Graduate Nurse.

REASONABLE AND CUSTOMARY CHARGE—An amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, and condition. The result of this comparison will determine the amount that is the maximum allowable charge to be considered a covered expense under this Plan.

ROOM AND BOARD CHARGES—All charges made by a hospital in its own behalf for room (semi-private rate) and board and general duty nursing care. This does not include any charges for professional services of doctors or private duty nurses or any charge for any individual nursing care, regardless of what it is called.

SELF-PAYMENTS—Payments made to the Fund by you or your dependents in order to continue Plan coverage under the rules governing COBRA Coverage. Payments that are remitted to the Fund by your employer on your behalf which are funded in whole or in part by payroll deduction are not considered self-payments.

SKILLED NURSING FACILITY—An institution, or a distinct part of an institution, which complies with all licensing and legal requirements and which meets all of the following criteria: it is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist them to reach a degree of body functioning to permit self-care in essential daily living activities; it provides 24-hour-a-day supervision by one or more doctors or one or more R.N.s; it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least hours a day; every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hospital; it maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; it has a utilization review plan; it has a transfer agreement with one or more hospitals; it is eligible to participate under Medicare; and it is not, other than incidentally, a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

TREATMENT FACILITY FOR ALCOHOLISM AND/OR DRUG ABUSE—A rehabilitation facility for the treatment of persons suffering from alcoholism and/or drug abuse or drug addiction. To be considered an approved treatment facility for the purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or meet certain requirements specified by the Trustees.

38. Services, supplies, or hospital confinements the covered person is not required to pay for.
39. Charges incurred that would not have been made if this Plan did not exist.
40. Services or supplies provided for or in connection with a radial keratotomy or any other type of surgical reshaping of the cornea for the purpose of enhancing vision.

Additional Exclusions and Limitations:

- The Plan will not pay benefits in excess of \$2,000 for charges incurred for treatment of a sickness or injury of your foster child if the child's condition, sickness or injury existed prior to the child becoming your foster child (as described in the "Definition of Child" on page 28).
- No Plan benefits will be payable under any specified Plan benefit or for a particular type of care or treatment once a covered person has already received Plan benefits totaling any applicable maximum benefit under that benefit or for that type of care and treatment during any stated time period.

The preceding list is not an all-inclusive listing of Plan conditions, limitations and excluded procedures, services or supplies. It is only representative of the types of situations for which no payment, or limited payment, is made. Basically, benefits are only payable under this Plan for the direct treatment of non-occupational accidental injuries and sicknesses.

GENERAL PLAN PROVISIONS

PAYMENT OF BENEFITS — Benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefit shown for each benefit on the Schedule of Benefits for each Class. Benefits are payable when the required forms have been provided by the Welfare Fund Office to the Contract Administrator.

All benefit payments will be made to you (even if the claim is for one of your dependents) unless you assign benefits. However, if a person who is your dependent is not a member of your household, benefits for treatment of such dependent may be payable to the dependent or, if the dependent is a minor, to the adult who has custody and care of the minor, unless benefits are assigned.

To assign benefits, you or your spouse complete the assignment section on a claim form or complete an assignment form from your doctor's office, a hospital, etc. The bills will be sent directly to the Welfare Fund Office. The Contract Administrator will make payments directly to the hospital, doctor, etc. You are responsible for paying any amounts not paid by the Plan.

If the Trustees decide that a person is not physically, mentally, or otherwise capable of handling his business affairs, and no guardian has been appointed for him, the Trustees may make payment to the individual (or individuals) who has assumed the care and principal support of that person. If the person dies before all amounts that are due have been paid, the Trustees may make payment to the executor or administrator of the person's estate, to his surviving spouse, parent, child or children, or to any individual who, in their opinion, is entitled to the benefits.

A charge for any service or supply will be considered to have been incurred on the date that the service was rendered or the supply was provided.

NOTICE AND PROOF OF CLAIM — TIME LIMITS

1. If you have a claim, you must **notify** the Welfare Fund Office within 90 days of the date that the sickness started or the injury occurred. A phone call or a simple statement written to the Welfare Fund Office will satisfy this rule as long as you give identifying information about the person the claim is for. If you do not furnish notice within 90 days, your claim will not be endangered if you show that you provided notice as soon as it was reasonably possible.
2. As soon as your notice of claim is received by the Welfare Fund Office, you will be furnished with forms for filing **proof** of claim. If the forms are not furnished to you within 15 days after the Welfare Fund Office has received notice of claim, you will be considered to have complied with the requirements for proof if you submit written proof within the time limits stated below, describing the person the claim is for, the injury, sickness or disability the claim is for, and any bills for treatment of the injury or sickness.
3. Your written proof of loss of time due to disability must be furnished within **90 days** after termination of the period for which claim is made. Proof of any other loss (claim) must be furnished within **90 days** after the date of the loss. If you do not provide proof of loss within these time limits, payment of your claim will not be endangered if you show that it was not reasonably possible to furnish the proof when required and the proof was furnished as soon as it was reasonably possible.

RELEASE OF INFORMATION — You must provide the Welfare Fund Office or Contract Administrator with any required authorizations for release of necessary information relating to any claim you have filed.

EXAMINATIONS — The Trustees have the right to have a doctor of their choice examine a claimant when and as often as they may reasonably require while a

claim is being processed. The Trustees also have the right to examine any and all hospital or medical records relating to a claim and to ask for an autopsy in the case of a death, provided an autopsy is not forbidden by law.

FREE CHOICE OF PHYSICIAN — You will have free choice of any doctor who meets the Plan's definition of a doctor.

WORKERS' COMPENSATION NOT AFFECTED — This Plan is not in lieu of any Workers' Compensation Law or Occupational Diseases Law or similar law. This Plan does not affect any requirement for coverage under any Workers' Compensation Law or Occupational Diseases Law or similar law.

TRUSTEE AUTHORITY AND RIGHT — Under the Plan of Benefits and the Trust Agreement creating the Welfare Fund, the Trustees or persons acting for them, such as a claim review committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary and capricious.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted you under the Plan are legally enforceable.

GOVERNING LAW — All questions pertaining to the validity or interpretation of the Trust Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists.

SUBROGATION — If you file a claim for medical expenses and a "third party" is legally responsible for paying those expenses, **the Plan will not pay benefits on the claim unless the requirements of the Subrogation Rules stated below are met.** A "third party" is any person or corporation (or any insurance company obligated to pay claims resulting from the acts of such a person or corporation) which is or may be found legally responsible to pay your medical expenses. The subrogation rules do not apply to payments made under your own insurance policy.

Subrogation Rules—If a third party is responsible for paying expenses for which you file a claim, the Plan will only pay benefits on the claim under the following conditions:

1. You must sign a Subrogation Agreement as follows:

- a. You agree that you will repay the Plan the amount of benefits which the Plan pays on the claim out of any recovery of expenses you may make, or you recover that much; and
 - b. You agree that, if the third party does not voluntarily pay you for the incurred expenses and you do not sue the third party for recovery of the expenses, the Plan has the right to sue the third party in your name to recover the amount it paid. In such a case, if there is a recovery or settlement, you agree that the Plan's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement; and
 - c. You agree not to assign to any other person your right to recover the amount of the incurred expenses.
2. If the expenses are incurred by a minor dependent child, you or the child's legal guardian must sign the Subrogation Agreement on behalf of the child.
3. If you make a recovery of incurred expenses and do not repay the Plan as you agreed to do when you signed the Subrogation Agreement, the Plan may file suit against you to recover expenses it paid on your claim. The Plan also has the right to reduce any future benefits you may be entitled to on claims for yourself and your dependents until the proper amount has been recovered by the Plan.

4. The Plan will not expect repayment of more than the benefits it pays on the claim or more than the amount you receive in recovery.

Restoration of Recovered Benefits — If a person has a claim which is subject to subrogation and the Plan pays benefits on the claim, the benefits paid by the Plan apply toward all applicable maximum benefit limitations the same as benefits which are paid for non-subrogation claims.

If the Plan pays benefits under the subrogation rules and **recovers** some or all of the benefits it paid through subrogation, the amount of benefits recovered may be restored to certain maximum benefits. The following rules apply to restoration of recovered benefits:

- Recovered benefits will not be restored to benefit maximums that pertain to a specific accident or injury.
- Recovered benefits will be restored only to benefit maximums that are capped by lifetime, calendar year or other period of time limitations.
- A restoration will be effective on the date the recovery is received by the Plan.

custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.

- d. If you and your spouse are both covered as employees under this Plan, benefits for claims for your dependent children will be coordinated, subject to the above rules.

If the above rules still do not clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

C.O.B. WITH MEDICARE

FOR EMPLOYEES CONTINUING TO WORK AFTER AGE 65 — If you continue to work for a contributing employer who has **20 or more employees** after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays. If she is covered under her own plan, her plan will pay first, this Plan will pay second, and Medicare will pay last.

You (and/or your spouse) can decline coverage under this Plan. If you do, Medicare will be your **only** health care coverage. If you and/or your spouse prefer Medicare as your only health care coverage when you are age 65, contact the Contract Administrator (or your spouse should notify her own plan). Unless you make such a choice, this Plan will continue to pay primary benefits for you (and its normal benefits for your spouse) **as long as you stay regularly eligible**.

NOTE: If you to continue to work for a contributing employer after you or your spouse is age 65 and eligible for Medicare, **and** if your employer has **fewer than 20 employees**, Medicare will be your primary provider of health care benefits and this Plan will be secondary.

FOR PERSONS UNDER 65 — If any covered person is entitled to Medicare for reasons **other than being 65 or older** (for example, because of disability or being an End Stage Renal Disease beneficiary), in most circumstances this Plan will pay its normal benefits on that person's claims before Medicare pays its benefits unless the Plan is legally allowed to pay after Medicare pays.

ENROLLMENT IN MEDICARE — You and your spouse are each responsible for enrolling in Medicare Part A and Part B when eligible to do so. At present, there is no cost to you for Part A, which provides hospital benefits. Part B covers such items as doctors' services. The government makes a small monthly charge for Part B.

If a family member is eligible to enroll in Medicare, benefits will be paid as though he were enrolled, whether or not he is actually enrolled. If you want information about Medicare enrollment, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

BENEFIT CREDIT

If the Plan saves money on a claim for a person by using C.O.B. during a year, the amount of savings is credited on that person's record as a "benefit credit." If a person has a benefit credit on his record from a previous claim (or claims), the Plan will pay his covered expenses on the next claim at 100% until his benefit credit is used up. A separate benefit credit record is kept for each Plan benefit and used only for claims incurred under that benefit. In other words, a benefit credit under the Major Medical Benefit could not be applied to benefits on a claim for Dental Benefits.

No benefit credit will be applied to charges incurred before the date the savings were realized by the Plan. Also, a benefit credit earned by one member of your family may not be applied to a claim of another member of the family. Benefit credits are based on a calendar year. At the end of each calendar year, any benefit credits on a person's record are deleted and a new benefit record is started for the following calendar year.

CLAIM REVIEW PROCEDURE

When you have a claim, be sure to follow the proper claim filing procedures. If a claim is denied by the Contract Administrator in whole or in part, you will receive a written notice stating the specific reasons for the denial, the specific Plan provisions on which the denial is based, and a description of any additional material or information needed to perfect your claim. You will also be given an explanation of the claim review procedure. Claims will be approved or denied within 90 days, unless additional time (up to 90 more days) is required, in which case you will be notified.

CLAIM DENIALS — A denial of benefits occurs when all or part of a claim is denied by the Contract Administrator after receipt of all information you provide in support of your claim. You have the right to request a review of the claim.

CLAIM REVIEW PROCEDURE — To obtain a review of a claim after a denial of benefits, you must write a letter to the Board of Trustees requesting a review. State your reasons for requesting the review and attach any additional information that you think will help a favorable decision to be made on your claim. **Your letter must be sent to the Board of Trustees within 60 days of the date the denial was mailed to your last known address.**

To file a request for review, send your letter to the:

Board of Trustees
Suburban Teamsters of Northern Illinois Welfare Fund
W. J. Haynes and Company
7045 North Western Avenue
Chicago, Illinois 60645

You can legally authorize someone else to file your request for review and otherwise act for you. You and/or your representative can review materials in the Fund's files that are related to your claim. You and/or your representative can submit written comments and other material to support your request for review.

The Trustees will review all of the material submitted with your claim, the previous action taken on the claim by the Contract Administrator, and the additional information you have provided. You will be informed in writing of the Trustees' decision within 60 days of the date that you filed your request for review. (In unusual circumstances, up to an additional 60 days may be required.) The decision will state the reasons for the decision and include specific reference to the provisions of the Plan documents upon which the decision was based.

If your request for review concerns a matter covered by an insurance policy, it will be referred to the insurance carrier for review.

You may not file legal action against the Plan to recover benefits until all of the proper claim review procedures have been followed.

(See below for circumstances which may result in loss of eligibility or benefits.)

CIRCUMSTANCES UNDER WHICH ELIGIBILITY FOR BENEFITS MAY BE DENIED OR LOST

1. Failure to make a required COBRA self-payment to the Fund when it is due.
2. Failure to convert your life insurance to an individual policy within 31 days after your eligibility for life insurance terminates.
3. Failure to notify the Contract Administrator of a handicapped dependent child's handicap before the child becomes age 19.
4. Failure by your employer to make contributions to the Fund on your behalf and on behalf of your fellow employees.
5. Failure to provide proof of claim within 90 days after the event on which claim is based, or failure to furnish, when requested, information or documents available to you when necessary to complete a claim.
6. Failure to furnish required documentation when requested such as a marriage certificate, birth certificates, adoption papers, court orders, divorce decrees, etc.
7. Failure to continue working in covered employment.
8. Termination of the Plan of Benefits by the Board of Trustees.

Other provisions covering termination of your eligibility and termination of your dependents' eligibility are stated in the "Eligibility" section on pages 45-46.

CIRCUMSTANCES WHICH MAY RESULT IN DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny benefits. The following list outlines some circumstances or reasons that all or part of a person's claim may be denied by the Contract Administrator or that would cause a person to lose benefits or to receive reduced benefits.

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.

2. You did not file the claim within the Plan time limits.
3. The expenses that were denied are not considered covered expenses under the Plan, or the expenses for which you filed the claim were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time, for instance a calendar year maximum benefit, a lifetime maximum benefit, etc.
5. Some other plan was primarily responsible for paying benefits on the expenses.
6. No payment, or a reduced payment, was made because some or all of the expenses were applied against a deductible.
7. A third party, such as the driver of a car that caused an accident for which medical expenses were incurred, was responsible for paying the expenses and you did not sign the required Subrogation Agreement which would permit the Plan to pay your claim and recover payment from the third party or his insurance company.
8. The Plan of Benefits was terminated.
9. For **Classes C and D**, a non-PPO hospital was used and benefits were reduced by the additional deductible and paid only on a co-pay percentage basis.

YOUR RIGHTS UNDER ERISA

As a participant in the Suburban Teamsters of Northern Illinois Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office or the office of the Board of Trustees and at other specified locations, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Upon written request to the Plan Administrator, obtain copies of all Plan documents and other Plan information, including a complete list of the names and addresses of employers sponsoring the Plan, or information as to whether a

particular employer is a Plan sponsor and, if so, the employer's address. A reasonable charge may be made for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

HOW TO READ OR GET PLAN MATERIAL - You can read the material listed in the above section by making an appointment at the Welfare Fund Office during normal business hours. Also, copies of the material will be mailed to you if you send a written request to the Welfare Fund Office. There may be a small charge for copying some of the material, so call the Welfare Fund Office to find out the cost before requesting material. If a charge is made, your check must be attached to your written request for the material. The Welfare Fund Office address and phone number are shown on the inside front cover of this booklet.

RESTATED AGREEMENT AND DECLARATION OF TRUST

CREATING THE

SUBURBAN TEAMSTERS OF
NORTHERN ILLINOIS WELFARE FUND

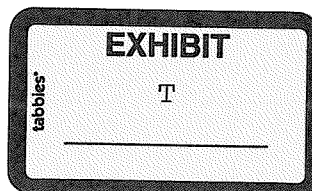
THIS RESTATED AGREEMENT AND DECLARATION OF TRUST, made and entered into this 12th day of October, 1977, by and between LOCAL UNION NO. 179, LOCAL UNION NO. 330, LOCAL UNION NO. 423 and LOCAL UNION NO. 673, affiliated with the INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN AND HELPERS OF AMERICA (hereinafter referred to as the "Unions") on behalf of all employee-beneficiaries hereof, the Employers obligated to make contributions to this Welfare Fund under the terms of Collective Bargaining Agreements, and HOWARD A. FLOYD, ROBERT VENARD, VINCE CRNKOVIC, JARL PETTERSEN, ERNEST R. LUDWIG, WALTER SCHOCK, RICHARD L. SCHIEK and PAUL LAMBRECHT, all of whom are presently all of the Trustees of SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND (hereinafter referred to as the "Trust"):

WITNESSETH:

WHEREAS, the Unions and the Employers heretofore established a Trust for the purpose of providing and maintaining hospital, surgical and other health and welfare benefits for certain employees of the Employers and their beneficiaries, said Trust having been created on the 27th day of October, 1955 and amended from time to time thereafter, under the name of LOCAL #179 (Joliet, Illinois), LOCAL #330 (Elgin, Illinois) AND LOCAL #423 (Aurora, Illinois), I.B.T. WELFARE FUND, and the name of said Fund having been amended as of the first day of February, 1958, to be SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND; and

WHEREAS, the Unions have heretofore entered into Collective Bargaining Agreements providing that the Employers shall contribute to the Welfare Fund specified amounts of money on behalf of each employee covered by the said Collective Bargaining Agreements; and

WHEREAS, HOWARD A. FLOYD, ROBERT VENARD, VINCE CRNKOVIC, JARL PETTERSEN, Employee Trustees, PAUL LAMBRECHT, ERNEST R. LUDWIG, WALTER SCHOCK and RICHARD L. SCHIEK,



the Trust for the direct payment of any benefits which have been contracted for by the Trustees in the case of the default of the insurance carrier or otherwise.

3.17 The Trustees may pay or provide for (1) the payment of all reasonable and necessary expenses of collecting the Contributions and administering the affairs of this Trust, including the employment of such administrative, legal, expert and clerical assistance that they determine to be necessary, (2) the leasing of such premises that they determine to be necessary for the administration of the Trust, and (3) the purchase or leasing of such materials, supplies and equipment that the Trustees, in their discretion, find necessary or appropriate to the performance of their duties.

3.18 The Trustees shall have the power to construe the provisions of this Restated Agreement and Declaration of Trust and the terms and regulations of the Plan of Benefits; and any construction adopted by the Trustees in good faith shall be binding upon the Unions, the Employers, all parties dealing with the Trust and all persons claiming any benefits from the Trust.

3.19 The Trustees, by resolution, shall provide for fidelity bonds, in such form and amounts as may be required by statute, for their employees and for the Trustees who shall be authorized to handle assets of the Trust Fund. If no such statutory requirement shall exist, such bonds shall be in such form and amounts as the Trustees may determine. In addition, the Trust may by resolution purchase insurance for its fiduciaries and for itself to cover liabilities or losses occurring by reason of the act or omission of a fiduciary; provided, however, that such insurance policy shall be in the form and manner permitted by law.

3.20 The Trustees are authorized to extend the coverage of this Restated Agreement and Declaration of Trust to such other Employers as the Trustees shall agree upon, provided such Employers are required and agree to conform to the terms and conditions hereof and to make Employer Contributions pursuant to a Collective Bargaining Agreement with a Union.

3.21 The Trustees are authorized to negotiate, direct and agree to the merger of this Trust with, or into another

ARTICLE V

Controversies and Disputes

5.01 In any controversy, claim, demand, suit at law or other proceeding between the Trustees and any employee-beneficiary or any other person claiming any benefits from the Trust, the Trustees shall be entitled to rely upon any facts appearing in the records of the Trust, any instruments on file with the Trustees, with the Unions or with the Employers, any facts certified to the Trustees by the Unions or the Employers, any facts which are of public record and any other evidence pertinent to the issue involved.

5.02 All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with the Trust or the operation thereof, whether as to any claim for benefits, or whether as to the construction of the language of this instrument, the Plan of Benefits, or the rules and regulations adopted by the Trustees, or as to any writing, decision, instrument or accounts in connection with the operation of the Trust or otherwise, shall be submitted to the Board of Trustees for decision, and the decision of a majority of the Board shall be binding upon all persons dealing with the Trust or claiming any benefit thereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.

5.03 The Trustees may, in their sole discretion, compromise or settle any claim or controversy in such manner as they think in the best interests of the Trust and its beneficiaries, and any decision made by the Board of Trustees in compromise or settlement of a claim or controversy, or any compromise or settlement agreement entered into by the Trustees, shall be conclusive and binding on all parties to the Trust, all persons dealing with the Trust, and all persons claiming any benefits thereunder.

such payment until a binding adjudication of such question or dispute, satisfactory to the Trustees in their sole discretion, shall have been made, or the Trustees shall have been adequately indemnified to their satisfaction against loss.

9.04 This Restated Agreement and Declaration of Trust shall be construed according to and be governed by the laws of the State of Illinois, except as may be provided by federal law.

9.05 Where used in this Restated Agreement and Declaration of Trust, words in the masculine shall be read and construed as in the feminine, and words in the singular shall be read and construed as though used in the plural, in all cases where such construction would so apply.

9.06 The Article titles are included solely for convenience and shall, in no event, be construed to affect or modify any part of the provisions of this Restated Agreement and Declaration of Trust or be construed as part hereof.

9.07 Should any provision of this Restated Agreement and Declaration of Trust be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of the Trust. No Trustee shall be held liable for any act done or performed in pursuance of any provisions hereof prior to the time such act or provision shall be held unlawful by a court of competent jurisdiction.

9.08 No person shall have any vested interest or right in the Trust Fund or in any payments from the Trust except as may be provided in any Plan of Benefits adopted by the Trustees, from time to time; provided, however, that the rights of any person who has become eligible for benefits hereunder by fully meeting the requirements of this Restated Agreement and Declaration of Trust or any Plan of Benefits created hereunder shall not be affected, changed, or altered by any amendment hereto, unless the Trust Fund, in the opinion of the Trustees, is inadequate to meet the payments due, in which event the Trustees shall determine whether such benefits shall be reduced uniformly or the Trust terminated.

IN WITNESS WHEREOF, the undersigned have caused this Restated Agreement and Declaration of Trust to be executed on the date first above written.

Howard A. Floyd
HOWARD A. FLOYD, Trustee

Richard L. Schiek
RICHARD L. SCHIEK, Trustee

Robert Venard
ROBERT VENARD, Trustee

Ernest R. Ludwig
ERNEST R. LUDWIG, Trustee

Vince Crnkovic
VINCE CRNKOVIC, Trustee

Walter Schöck
WALTER SCHÖCK, Trustee

Jarl A. Pettersen
JARL A. PETTERSEN, Trustee

Paul Lambrecht
PAUL LAMBRECHT, Trustee

UPON THE RECOMMENDATION OF:

Barren Transfer Co
Employer

Local Union No. 330, Inter
national Brotherhood of Teamsters
Local Union

By: Walter Schöck Oct 12, 1977
Date

By: Howard A. Floyd Oct 12, 1977
Date